

# **INDIAN HEALTH SERVICE RESOURCE AND PATIENT MANAGEMENT SYSTEM**



## **BEHAVIORAL HEALTH SYSTEM Patient Chart v1.5 Behavioral Health GUI**

### **TRAINING MANUAL**

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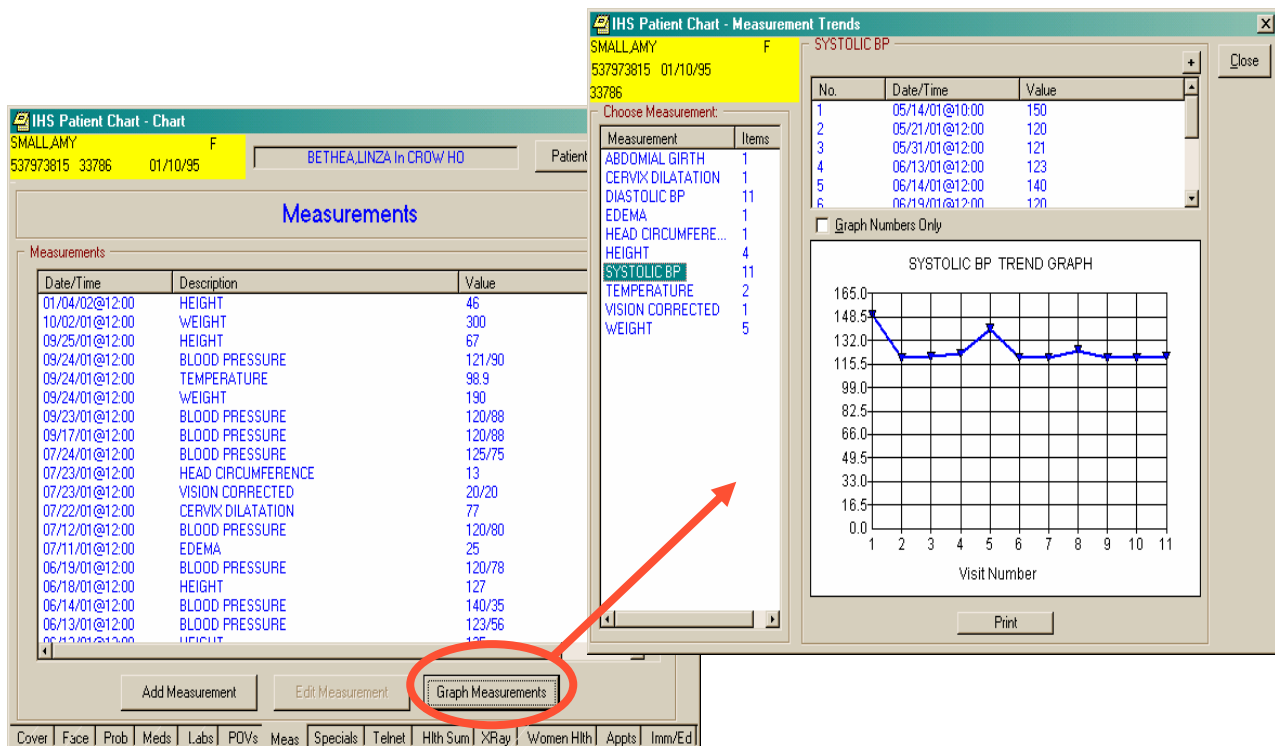
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## Introduction to Patient Chart

Patient Chart is a Windows-like “front end” to RPMS designed for use by clinical providers. It provides a Visual Basic graphical user interface to Mumps server software. All of the displayed data in Patient Chart comes from the clinical RPMS applications running at a site, e.g., Lab, Pharmacy, RCIS, etc.

The Patient Chart interface is primarily patient-centric and is intended to assist providers in

- reviewing and updating patient information prior to or during patient visits;
- ordering laboratory tests, medications, and referrals; and
- entering and editing some types of patient data directly, e.g. measurements, behavioral health encounters and treatment plans, etc.



Windows –based design

## History

The Patient Chart concept was initially developed by two programmers in 1997. Their goal was to offer providers an easy-to-use alternative to RPMS roll and scroll applications. As an “unofficial” project, various versions were tried out at different sites, with direct input from providers in the field regarding functionality. An informal beta version was available for interested sites in August 2000. Formal beta testing began in June 2001 at San Xavier, Cherokee, and Whiteriver. Initial certification occurred in late October with formal release in early December 2001. Enhancements were developed and tested in 2002 and the Behavioral Health (BH) tab was developed in 2003. During this development phase, usability analysis and a user-centered design approach was undertaken in an effort to develop a user-friendly BH component that supported direct provider entry of clinical data. The latest version, BH GUI v1.5, including the BH tab, was certified and released in June 2005.

## Security

Log on: Patient Chart requires the user to have RPMS Access and Verify codes. After three unsuccessful attempts to log on, the session is terminated. No patient data is stored in the client software on the user's computer. When a session is completed, all data is erased from cache (memory).

Role-based access: Users have access to buttons, tabs or options depending on their function (role). This allows the site manager to create a custom interface for each user by assigning *security keys* to each button. For example, if the user isn't allowed to order labs, the Order Labs security key is not assigned and the control is grayed out or invisible.

## Why Would Providers Use Patient Chart?

- Secure access to the most up-to-date clinical information;
- User-friendly, intuitive interface supports provider entry of clinical information;
- Graphical user interface decreases RPMS training time for new and part-time providers.

## How will Patient Chart improve the quality of care?

- Clinical documentation is more accurate and timely;
- Patient safety and privacy is enhanced by electronic provider entry of clinical information;
- Patient information is readily available at the point of care enhancing continuity of care.

## Workflow Assessment and Business Processes

Implementing the Behavioral Health GUI may change how you do business. It is recommended that you identify your current workflow and plan for any changes before implementation. Your program's policies and procedures should reflect the use of an electronic behavioral health record system to document clinical care.

## Sites Should Think About...

- Convenient and secure access to computers and printers for providers;
- Performance depends on both client and server hardware – preferred specifications are listed in the Technical Manual;
- Process change will be required when using provider entry – consult with behavioral health and primary care providers, ancillary care staff, and data entry and medical records staff before implementing.

## **Practice Scenarios**

**A.** *Your client has been referred to you for mental health services. He indicated that he has received mental health services previously from your program but cannot recall the exact dates or provider(s) of service.*

- 1. Locate the patient record.**
- 2. Review the Behavioral Health Summary.**

**B.** *Your patient is being monitored for weight changes every time she comes for an appointment.*

- 1. Access the measurements screen and graph the measurements.**
- 2. Add a weight value for today's visit.**

**C.** *Your patient has been admitted to the RTC and is getting a physical. Enter the following measurements:*

- 1. Blood Pressure of 125/85**
- 2. Weight**
- 3. Height**

## Introduction to BH GUI

The Behavioral Health component within Patient Chart was designed to encourage direct provider entry of clinical data via a graphical user interface (GUI) and ultimately to improve patient outcomes and data collection. The BH tab within Patient Chart v1.5 is a Windows-like “front-end” to the Data Entry module of the existing RPMS application, BHS v3.0. The BH GUI was developed with input from IHS, Tribal and Urban (I/T/U) behavioral health providers and is intended to improve case management and patient outcome by facilitating the efficient review and documentation of clinical services provided. Direct provider entry improves the accuracy of clinical notes, reduces errors, and helps protect patient confidentiality. The BH applications will continue to permit the entry of clinical data by support or data entry staff and most I/T/U behavioral health programs will continue to use a hybrid system of computerized and paper-based patient records. However, with the successful deployment of BHS v3.0 and BH GUI within Patient Chart, Behavioral Health is at the forefront of the health care industry and I/T/U movement toward the use of an electronic health record.

### Purpose:

The purpose of this BH GUI training is to give the user the skills and knowledge needed to use the BH GUI to review and record clinical data efficiently and effectively in order to improve patient care and management.

### Goal:

Upon completion of this course the user will be able to use the BH GUI to accurately record, edit, view, and print patient encounters for all visit types, including Mental Health, Alcohol/Substance Abuse, and Social Work. The user will be able to accurately record, edit, view and print group encounters, treatment plans, incidents of suicide and administrative activities.

### Objectives:

1. **Set Up** -- Access BHS v3.0 site parameters and select defaults, type of link to PCC, and SDE function.
2. **Patient Related Data Entry** – Enter patient-related data entry including an encounter record, Suicide Form, treatment plan, patient Information and case status.
3. **BH Options** – Access the BH Options and record all required elements for group encounters, non-direct patient activities, and an encounter record in the Visit Entry format.
4. **Reports** – Use the Telnet function to access the Reports menu in BHS v3.0, identify specific reports, and run a sample report.
5. **Exporting** – Routinely export behavioral health data to headquarters using the Export utility menu.

## Objective #1: Set Up

Access BHS v3.0 site parameters and select defaults, type of link to PCC, and SDE access.

### Purpose:

The purpose of this lesson is to introduce you to the set-up options and security features that are available in both BHS v3.0 and BH GUI.

### Overview:

It is important that users of the BH GUI, regardless of their discipline, recognize the purpose of the site parameters and links to PCC.

### Skills You Will Acquire:

Upon completion of this objective you'll be able to:

- Identify the various fields within the BHS v3.0 site parameters
- Discuss the five types of links to PCC
- Explain the purpose of the SDE function

### Log On

1. Log onto RPMS BHS v3.0
2. At the IHS Kernel Option, access Behavioral Health as instructed by your site manager.
3. At the Behavioral Health System display, select MUTL, Manager Utilities.
4. On the next screen, select Site Parameters.

**Reminder:** Site Parameters are controlled by security keys. If you do not have the key for this function, please contact the facility IT department or RPMS site manager to set up or edit the parameters.

### Adding/Editing Default Values in Data Entry

Defaults are entered based on type of service – Mental Health, Social Service or Chemical Dependency. Location and Community are often the same for each type of service while the clinic may vary. If the server is used by only one facility providing one type of service, all defaults would be the same.

1. Enter the name of the Location. RPMS conventions apply so you may enter the first part of the name, ??? to see the entire list, etc.
2. Enter the name of the community where service is provided.
3. Enter the type of clinic (from the standard IHS list).

```
*****  DEFAULT VALUES IN DATA ENTRY  *****
MH Location: DULCE HEALTH CENTER      SS Location: DULCE HEALTH CENTER
MH Community: DULCE                    SS Community: DULCE
MH Clinic: MENTAL HEALTH               SS Clinic: MEDICAL SOCIAL SERVI
More Defaults (press enter):
```

4. Repeat Steps 1-3 to enter the Social Service defaults.
5. Press [Enter] to access the additional defaults.

```

Default Chemical Dependency Location: DULCE HEALTH CENTER
Default Chemical Dependency Community: DULCE
Default Chemical Dependency Clinic: ALCOHOL AND SUBSTANCE

Default Type of Contact: OUTPATIENT
Default Appt/Walk In Response: APPOINTMENT

```

6. Repeat Steps 1-3 to enter defaults for Chemical Dependency services.
7. Select the most frequently used type of contact – applies to all three sets of defaults.

09	Group Services
11	Home
14	Mental Health
22	School
25	Other
30	ER
43	Alcohol & Substance Abuse
48	Medical Social Services
51	Telephone Call
52	Chart Review
77	Case Management Services

*More choices may be found by entering ??? at the prompt*

8. Select the most frequently used value for Appointment, Walk In or Unspecified.
9. Press [Enter] to return to the Site Parameters view.

### **Adding/Editing Type of PCC Link**

```

Type of Visit to Create in PCC: IHS      INTERACTIVE PCC LINK?
Type of PCC Link: PASS ALL DATA AS ENT  Allow PCC Problem List Update?
Update PCC Link Exceptions? N Update those allowed to see all visits on SDE?

```

#### **1) No Active Link**

The data link between the two modules is not turned on. No data is passed to the PCC visit file from the MH/SS system.

#### **2) The Data Link is on. All records are the same.**

Patient contacts in the Behavioral Health programs are passed to the PCC visit file. The same ICD-9 code and narrative, as defined by the program, are used for all cases.

#### **3) The Data Link is on. Some Masking of Data.**

Patient contacts in the Behavioral Health program are passed to the PCC visit file according to the manner in which the Purpose of Visit (POV) is recorded.

- If the POV is identified using a DSM-IV diagnostic code, the equivalent ICD-9 diagnostic code along with the standard narrative, prefaced with the phrase, "Diagnostic impression" is passed to PCC.
- If a psychosocial problem is characterized by using a MH/SS Problem Code as a POV, the ICD-9 code and the narrative as shown in the crosswalk table are passed to PCC. Potentially sensitive issues may be appended by the phrase, "See (Provider's Name) for Details of this Contact".

There are two exceptions:

- For MH/SS Problem codes 39 (Suicide Ideation) and 40 (Suicide Attempt/Gesture), the ICD-9 code and standard narrative are accompanied by the provider's actual narrative.
- For problem codes 42 (Child Abuse) and 44 (Adult Abuse) the ICD-9 codes for those problems (995.5 and 995.81) have been added as acceptable DSM codes to allow an additional option for what gets passed to PCC. When these codes are used to characterize a POV, each gets passed "as is" along with the provider's narrative.

**4) The Data Link is on. No Masking of Data.**

All DSM IV and Problem Codes are passed as ICD-9 codes as shown in the crosswalk along with the narrative as written by the provider.

**5) The Data Link is on. Single standard narrative for all contacts.**

Both DSM IV and Problem Codes are converted to ICD-9 codes as shown in the crosswalk and passed with a single standard narrative, as defined by the program, for all contacts.

Select the type of link from the above list. Enter either the number or part of the name.

### **Updating Those Allowed to See All Visits in SDE**

The BH Options Visit Entry function is equivalent to the SDE Data Entry function in BHS v3.0. It allows the user to view all visits for all patients within a selected date range. It is a visit-centric view of data rather than a patient-centric view. This feature is controlled by the site parameter, Update those allowed to see all visits on SDE. If it is determined that a user should have access to the Visit Entry list view the user's name must be entered into this field at the prompt. The Visit Entry button on the BH Options screen will not be visible to the user if the user's name is not listed in this site parameter.

If the facility is multi-divisional, the SDE function must be completed for each division where the user needs this level of access.

INTERACTIVE PCC LINK? Allow PCC Problem List Update? Update those allowed to see all visits on SDE?
---

1. At the prompt, type [Y] to access the data entry screen; press [Enter].
2. Type in the names of those individuals who need access to all patient information. Enter the name(s) using standard RPMS format – Last name,first name (no space between comma and first name).
3. Press [F1][C] to close the text box.
4. Press [F1][E] to exit site parameters and save the changes.

## Objective #2: Patient Related Data Entry

Enter patient-related data including an encounter record, Suicide Form, treatment plan, patient information and case status.

### Purpose:

The purpose of this exercise is to introduce you to the various types of patient-related documentation that can be entered through the BH GUI.

### Overview:

It is important that users of the BH GUI, regardless of their discipline, be able to enter accurate patient-related data. Complete and accurate data is critical for many reasons including, most importantly, patient outcome but also for billing purposes and program management and planning.

### Skills You Will Acquire:

Upon completion of this objective you'll be able to:

- Recognize the different types of visit documentation and identify the required fields.
- Summarize the importance of Suicide Surveillance and enter suicide data using the Suicide Tab in BH GUI.
- Complete a client-specific Treatment Plan.
- Identify the purpose of the Patient Information and Case Status Tabs.

### Log On

1. Log onto BH GUI
2. On the Options screen, choose "Select Patient"
3. Type in the Patient's name, Social Security #, or Medical Record # and click [Display].
4. Click on the BH Tab

**Note:** When the visit tab is selected, a List View of previous encounters may appear. This list view is used for editing, deleting, or viewing patient encounters.

### Encounters - Adding Visit Information (Top portion of data entry screen)

All patient-related visit types have the same visit information section and three basic tabs – POV, CC/SOAP, and Visit Admin. Depending on the type of visit selected, additional tabs included may be the Rx; Wellness; Intake; SAN (New); SAN (Follow Up); CD Data; and/or CD Staging.

1. Select the "Visit" tab and choose [Add] to enter a new encounter record
2. On the "Enter Visit Type" screen, select "Regular" from the drop down menu and click [OK].
3. At the top of the "Add Regular Visit" screen, enter the demographic data for the visit – provider, program, encounter date, etc.

### Encounters - Adding POV (Axes I – V)

1. Select the "POV" tab to enter Axes I – V codes.
2. Click on the [Add] button to enter Axis I, II, or IV value. A drop down menu will appear.
3. Search for a specific POV axis I, II, or IV code by entering one of the following in the space provided: the code, the description, or a "?" for a random search.

**Reminder:** If the option of passing information to PCC has been turned on, the selections made in this field will govern the information passed to PCC.

**Note:** You can search for valid values by entering a partial code or a partial description.

4. Highlight your selection and click [OK].
5. Add additional POVs by repeating steps 2-4.
6. Add Axis V (GAF Score) by positioning your cursor within the Axis V box located at the bottom of the page.
7. Key your GAF score (0-100)

### **Encounters - Editing/Deleting POV**

A POV or DSM diagnosis for Axes I or II cannot be edited, but the narrative attached to the numerical code can be. For example, if the clinician wants to change the narrative from Bipolar Disorder (POV 15) to Clinic Visit:

1. Highlight the code to be edited
2. Click on [Edit]
3. Change the narrative & click [OK]

If the wrong code has inadvertently been entered:

1. Highlight the code to be deleted
2. Click on [Delete]

**Reminder:** When deleting an item, a confirmation message is displayed. After confirmation, the item is permanently deleted.

To edit a free-text box such as Axis III on the POV tab, use either of the following techniques to delete information:

1. Highlight the section to be deleted & click the [Delete] key on the keyboard; or
2. Move the cursor to the end of the section to be deleted & use the backspace key to remove data.

Axis IV can only be edited by adding or deleting items.

### **Encounters - Adding SOAP/Progress Notes**

1. CC/SOAP Tab – enter Chief Complaint and SOAP or progress note. Information may be entered into the free-text boxes or pasted from a word processing program.
2. Type chief complaint data directly into free-text box.
3. Copy and paste SOAP or progress note narrative from Word or another word processing application.

#### **Copy & Paste**

To copy information from a word processing application to the BH GUI (or BHS v3.0)

- Type the document in the format you want to use
- Highlight the section(s) you wish to add to the GUI free-text box
- Click on [Edit] at the top of the window and select “Copy”
- Open the BH GUI and select the location where the data is to be added
- Click on [Edit] and select “Paste” to add the information in the free-text box; or, right click your mouse and select “Paste”
- Continue with the rest of the documentation and save the visit when completed.

## **Encounters - Editing CC/SOAP**

To edit a free-text box such as CC/SOAP, use either of the following techniques to delete information:

1. Highlight the section to be deleted & click the [Delete] key on the keyboard; or
2. Move the cursor to the end of the section to be deleted & use the backspace key to remove data.

## **Encounters - Adding Visit Admin**

1. Click on the drop down menu for “Activity”
2. Select Activity Code from the Job Aide and type in the number or first few letters of the description in the “Enter Activity” box. If a list of options is displayed, double click on the appropriate activity type.
3. “Activity Time” – enter time in minutes.
4. Number served – defaults to 1.
5. Other fields are optional.

**Reminder:** CPT codes will pass to the Third Party Billing package depending upon the choice of Activity and POV codes and the Link to PCC.

## **Encounters - Editing Visit Admin**

1. For items with drop down menus:
  - Click on the arrow for the drop down menu
  - Select a new code, description or type “?” to see the complete list
  - Click [Display]
  - Double click on the item selected
2. CPT Codes & Secondary Providers can only be edited by adding or deleting codes or names.

## **Encounters - Saving Encounter Data**

1. After reviewing and editing data as needed, click on [Save].

## **Encounters - Printing an Encounter**

2. On the Visit List View screen, highlight the encounter record you want to print.
3. Click on the [Print Encounter] button.
4. On the next screen, choose the encounter form option you want to print.
5. Click on the [Display] button to review the document before printing.
6. After reviewing the document, if no editing is needed, click the [Print] button.
7. If editing is needed, click the [X] button in the upper right corner of the screen to close the screen and return to the list view.
8. Highlight the visit and click the [Edit] button.
9. Follow the same procedure described above to view and print the document.
10. Click the [X] button in the upper right corner of the screen to close the screen and return to the list view.

### **Encounters - Printing a Record**

1. On the Visit List View screen, highlight the encounter record you want to print.
2. Click on the [Print Record] button.
3. After reviewing the document, if no editing is needed, click the [Print] button.
4. If editing is needed, click the [X] button to close the screen and return to the list view.
5. Highlight the visit needing correction and click the [Edit] button.
6. Follow the same procedure described above to view and print the document.

### **Encounters - Adding RX Notes**

This tab is used to track prescriptions that have been ordered or for other relevant medication information. It will appear on all visit types except Info/Contact and No Show.

#### **Rx Notes Tab**

<b>Title</b>	<b>Description</b>	<b>When to Use/Notes</b>
PCC Meds	<u><i>Display Only</i></u> Displays a list of all medications stored in the PCC database for the timeframe selected when choosing a patient.	Use this screen to view medications passed to PCC. Medications will only be displayed if: 1) the prescription is filled at the in-house pharmacy, and 2) the behavioral health application is on the same server.
Behavioral Health Meds	<u><i>Display Only</i></u> Displays a list of all medications and medication notes entered in the Prescription Entry box on the Rx Tab, within the timeframe selected when choosing a patient.	Use this screen to view historical entries in the Prescription Entry box.
Prescription Entry	Data Entry field used to record prescriptions ordered or other medication information.	Use this screen to record information on prescriptions given to the client; monitoring of medication compliance such as pill counts; or information received about other medications the client is currently taking such as antibiotics, beta blockers, etc. This is a free-text box with unlimited space.

### **Encounters - Adding Education (Wellness Tab)**

Patient Education and Health Factors are now displayed on the Wellness Tab. PCC Wellness information may be viewed by clicking on the radio button. Data entry for Patient Education and Health Factors is done on the BH Wellness screens only

1. Select a Regular, Intake, or A/SA visit type.
2. Enter all required data (as discussed above).
3. Select the Wellness Tab.
4. Select the Education Tab and click on [Add].
5. From the drop down menu, select the Education Topic & double click.
6. Click on Individual or group.
7. Enter the time spent providing patient education.
8. Select a level of understanding from the drop down menu & double click.
9. CPT Code: Provider may enter a code from the drop down menu.
10. Add comments when appropriate.
11. Click [OK] to save the information.

### **Encounters - Adding Health Factors (Wellness Tab)**

1. Select a Regular, Intake, or A/SA visit type.
2. Enter all required data (as discussed above).
3. Select the Wellness Tab.
4. Select the Health Factors Tab and click on [Add].
5. From the drop down menu, select the appropriate health factor & double click.
6. Optional: Select a level of severity (Minimum, Moderate, or Heavy/Severe) from the drop down menu and double click.
7. Optional: enter a number to represent quantity where relevant.
8. Comments – this free-text box can be used to indicate what the quantity means or any other information relevant to the health factor.
9. Click [OK] to save the information.

### **Encounters - Adding IPV/DV Screenings (Wellness Tab)**

1. Select a Regular, Intake, or A/SA visit type.
2. Enter all required data (as discussed above).
3. Select the Wellness Tab.
4. Select the Screening Tab and click on [Add].
5. From the drop down menu, select the appropriate screening result & double click.
6. Comments – this free-text box can be used to document reasons Unable to Screen or other clinically relevant information about the screening.

### **Encounters - Editing/Deleting Education, Health Factors and Screenings**

To edit an entry:

1. Highlight the code to be edited
2. Click on [Edit]
3. Change the information & click [OK]

If the wrong code has inadvertently been entered:

1. Highlight the code to be deleted
2. Click on [Delete]

**Reminder:** Changes made to the Encounter Record will not be saved until the user clicks on the [Save] button.

### **Encounters - Adding an Intake Document**

Documentation completed on the Intake Tab will print out as part of the Encounter Record. A separate Intake Document can be printed by accessing the record in BHS v3.0.

Copying and pasting an intake from another word processing application will work if the formatting within the document is simple. For example, check boxes, tables, etc. will not copy into this field. Formats can't be saved within the computer application; however, it is possible to copy from a previously entered document.

1. Select a Regular, Intake, or A/SA visit type.
2. Enter all required data (as discussed above).
3. Select the Intake Tab.
4. Enter free text or use the copy/paste functionality to complete Intake documentation.
5. Click on [Save].

## **Encounters - Entering the SAN New and SAN F/U Information**

1. Select a SAN New or SAN F/U visit type.
2. Enter all required data.
3. Select the SAN tab.
4. All fields are optional. If no data is available, leave the field blank.
5. Dates entered on these tabs must be in the MM/DD/YY format.
6. Click on [Save].

## **Encounters - Adding CD Staging**

The Staging Tool results can be entered on the CD Staging Tab which is displayed on the Intake, Regular and A/SA visit types.

1. Days Used Alcohol & Days Used Drugs – enter number of days client reports using alcohol and/or drugs in the past six months. Record all answers in days.
2. Alcohol-related Arrests – enter number of arrests within the past six months.
3. Days Hospitalized – Enter the number of days within the past six months that the client has been hospitalized due to alcohol-or-drug-related illnesses or complications.
4. Tobacco Use – Using the drop down menu, select the category that best describes the client's current use of tobacco products.
5. Drug Types – Use the drop down menu to identify all classes of substances the client reports using or abusing.
6. Stages – enter a score from 1 to 6 for each of the seven stages. After entering the score for the last stage, tab to the next field. The staging average will be calculated as the scores are entered.
7. Select a Recommended placement based on the staging average; select an actual placement and, if different than the recommended placement, enter a difference reason.

## **Encounters - Adding CD Data**

The A/SA Visit Type is the only visit type that includes the ability to enter the CD Data. The CD Data tab contains drop down menus to record the Component Code; Type of Component; and the Type of Contact.

1. Use drop down menus to enter the CD data – Component Code, Component Type, and Type of Contact.
2. Enter days in residential treatment and/or days in aftercare within the past six months, if appropriate.
3. Click on [Save] to save all visit information.
4. Return to the List View, highlight the visit, and click on [Edit]" to make changes to a previously saved encounter record (visit).

**Reminder:** In order to look at a complete list of options, a “?” may be entered in any field that has a display button beside it. For example, click on the drop down menu for the “Component Code”; enter a “?” in the Enter A/SA Component box and click on the [Display] button.

## **Suicide Form - Adding Data**

1. Select the Suicide Form tab.
2. Select [Add] to enter a new report.
3. Add a local case number (if used).
4. Use drop down menus to select provider, the date of the act, and the community where the act occurred.
5. Relationship status - using the pull down menu, select one.

6. Employment status - using the pull down menu, select one.
7. Education - if less than 12 years is selected, free text field will be highlighted & number of years completed should be entered.
8. Self Destructive Act - Choices are: Ideation with plan and intent; Attempt; Completed Suicide; Attempted Suicide with Homicide; Completed Suicide with Homicide.
9. Location of Act (not the community) - Choices are: Home or vicinity; School; Other; Work; Jail/Prison/Detention; Treatment Facility; Medical Facility; Other; or Unknown. If Other is selected, a free text field will be displayed where the specific name or type of location may be entered.
10. Use drop down menu to record number of previous attempts, based on information provided by the client
11. Lethality – select either low, medium or high.
12. Disposition – Choices are Alcohol/Substance Abuse Follow Up; In-Patient Mental Health Treatment (Involuntary); In-Patient Mental Health Treatment (Voluntary); Medical Treatment (ED or In-Patient); Mental Health Follow Up; Other; Outreach to Family/School/Community; or Unknown. If Other is selected, a free text field will be displayed where the specific type of disposition may be entered.
13. Method tab – select all that apply. If “Overdose” is selected, the user needs to add the categories of medications used in this attempt.
14. Substance Use tab – refers to substances involved in this incident, even if overdose was not the primary means. For example, the client got drunk so that he could “get up enough nerve to drive his car into the bridge abutment”. In this case, Alcohol would be selected on this tab. If Overdose is selected on the Method tab, then the categories of medications should also be selected on this tab.
15. Contributing Factors tab – select all that apply. If “Other” is selected, the free text box will be highlighted and an explanation should be entered.
16. Narrative tab – record in your own words events which you feel contributed to this suicide encounter. This is not the location for your SOAP or progress note. In addition to the textual description this field can also be used to record additional information such as the inpatient facility’s contact person and phone number, etc.

**Reminder:** Information added to the Suicide Form will not be saved until the user clicks on the “Save” button.

### **Suicide Form - Editing**

1. Return to the Suicide Form List View.
2. Highlight the entry to be edited and click on [Edit].
3. Make changes to the data as needed. If a drop down menu is available, click on the arrow, select the new data to be entered and add any descriptors if “Other” is selected.
4. When finished editing the fields, click [Save] to update the Suicide Form and return to the List View.

### **Suicide Form - Printing**

1. Return to the Suicide Form List View.
2. Highlight the Suicide Form to be printed.
3. Click on the [Print/View] button in the lower right corner of the screen.
4. Click on the [Display] button to display the suicide form on your screen.
5. Click on the [Print] button to print the Suicide Form.

### **Suicide Form - Deleting**

1. Return to the Suicide Form List View.
2. Highlight the entry to be deleted and click on [Delete].
3. Information has now been permanently removed from the record.

**Reminder:** If an encounter record (visit) has been entered, it is not deleted when the Suicide Form is deleted. To delete a visit, the user must go to the Visit List View, highlight the visit and click on [Delete].

### **Treatment Plan - Information (top half of screen)**

1. Date Treatment Plan Established & Case Admit Date – The Case Admit Date can't be after the Date Treatment Plan Established.
2. Resolve by Date – what is the target date for the completion of the goals outlined in the treatment plan?
3. Next Review Date – when will the team be reviewing the client's progress? This is a projected date for the next review and will display on the Treatment Plan List View screen. This date can never be the same day or before the "Date Treatment Plan Established".
4. Designated Provider – who is the primary provider of services? Who is writing the treatment plan?
5. Concurring Supervisor – Does your facility require a supervisor to sign treatment plans or is the Designated Provider authorized to sign treatment plans without a concurring supervisor's signature? If no signature is required, leave this field blank.
6. Concurring Date – enter the date the supervisor signed off on the Treatment Plan, if required.
7. Status – Choices are Active, Inactive or Resolved.

**Reminder:** This field may be updated at any time and should be changed to Inactive or Resolved if the client is no longer receiving services.

### **Treatment Plan - Adding the Diagnosis/Problem**

1. Enter POV or DSM Diagnoses in the Axis I or Axis II free-text boxes.
2. Enter any related medical diagnoses in the Axis III box.
3. Enter any values for Axis IV and enter the GAF (0-100) for Axis V.
4. Enter any information that may reflect the client's current situation. Client's problems may include difficulty adjusting to a new community as well as the need for medications, etc.

### **Treatment Plan - Adding the Plan Narrative**

1. Problems/Goals/Objectives/Methods. Information may be entered into the free-text boxes or pasted from a word processing program.
2. Click on the Save button and return to the Treatment Plan List View screen.

### **Treatment Plan - Printing or Viewing**

1. On the Treatment Plan List View screen, highlight the plan you want to view or print.
2. Click on the Print/View button.

3. Select the Treatment Plan, Treatment Plan Review, or Both button and then click [Display].
4. Review the plan onscreen and then click on the [Print] button to generate a hard copy, if desired.

### **Treatment Plan Reviews - Adding**

1. Return to the Treatment Plan List View.
2. Highlight the plan you want to review & click [Edit].
3. Select the Plan Review Tab.
4. Click on [Add] to enter a new review of this plan.
5. Enter the date of the treatment team meeting or date the review was signed as the "Review Date".
6. Enter a future date based on agency policy as the "Review Date". This recommended date will be displayed on the List View.
7. If a reviewing supervisor is required and the name was entered at the time the Treatment Plan was established, the Rvw Supervisor field will automatically populate with that name. This name can be changed by using the drop down menu.
8. To enter a list of the Review participants, click on [Add] and type in the participant's name and their relationship to the client. The [OK] button must be clicked before you can add additional participants or save the information.
9. Progress Summary is a free text box. You may type a brief summary in the box directly or use the copy and paste technique to enter information from a word processing document.
10. Click [OK] and the Review will be displayed in a List View on this tab. Although the information is displayed, it is not saved until the user clicks on the [Save] button.

### **Treatment Plan Reviews - Printing or Viewing**

1. On the Treatment Plan List View screen, highlight the Treatment Plan containing the Review you want to view or print.
2. Click on the [Print/View] button.
3. Select the Treatment Plan Review, or Both button and then click [Display].
4. Review the Treatment Plan Review onscreen and then click on the [Print] button to generate a hard copy, if desired.

### **Patient Information Tab - Adding Designated Provider(s)**

1. Use the drop down menu to select either the Designated Mental Health or Social Services provider.

**Reminder:** When using a drop down menu, the user must double click on the appropriate response before it will be entered in the data field.

2. Use the drop down menu to add the names of any other providers (must be in the provider file)
3. Designated Other Provider #2 – use this free-text field to record the names of other providers who are not in the provider file. For example, probation officer, school teacher, or local medical doctor.

### **Patient Information Tab - Adding Patient Flags**

Enter a number between 0-99 for the specific patient flag. Tab to the flag narrative field and enter an explanation of the flag.

### **Patient Information Tab - Adding Personal History Factors**

1. Click on the [Add] button.
2. Type part of the descriptor or enter a “?” to see a complete list of personal history factors for your facility.
3. Select a factor from the list or click “Cancel” to leave these fields.  
**Note:** Use the Multiple Select functionality to select more than one factor.

**Reminder:**  
Personal  
History Factors  
will be  
displayed on  
the Health  
Summary.

### **Patient Information Tab - Saving the Data**

1. The data will not be saved until the user clicks the [Save] button.
2. Subsequent changes will not be stored until this step is completed again.

### **Case Status - Adding Information**

1. Click on the [Add] button to enter new case status information. If any information has been entered previously for the same program, the user may need to use the edit function.
2. Enter the “Case Open Date” utilizing the drop down calendar. Case open date is generally thought of as the date of first contact.
3. Enter the program and provider using the drop down menus.
4. Enter the Primary Problem – what is the main reason for treatment?
5. If the client has not been admitted at this time, save the information and return to the List View.

### **Case Status - Editing**

1. At the Case Status List View, highlight the Case Status to be edited and click [Edit].
2. Enter additional information such as the “Case Admit Date” or “Date Case Closed” using the drop down menus.
3. If the Treatment Plan functionality in the BH GUI is being utilized, a Case Admit Date must be entered. Treatment Plan Reviews can’t be entered into the GUI without the “Case Admit Date”.
4. If “Date Case Closed” is being entered, the “Disposition” box will be activated and a reason must be entered before the information can be saved.

## **Additional Features**

1. **Most Recently Used** - keeps track of the last entries selected by the user for a given item. This feature creates a dynamic “pick list” of the more commonly selected items in a field with a large number of items. This functionality is present in the following fields: POV, Placement Disposition, CPT Code, Education Topic, Health Factors, and Activity Codes..
2. **Multi-Select** – allows the user to select multiple items from selected lists within BH GUI.

**Non-Adjacent items** – click the first desired item, hold down the Control (CTRL) key, click each additional item, and then click the OK button or press the [Enter] key.

**Adjacent items** – click the first desired item, hold down the shift key, click the last file in the sequence, and then click the OK button or press the [Enter] key.

**Other Windows conventions** – Standard Windows conventions such as pressing the shift and End keys simultaneously will work to select all items.

3. **Multiple Divisions** – the new key BPCDIVALL will allow the user to select a patient from any division. If you have multiple divisions on your server and would like information on this key, please see the BH GUI User Manual.

## Practice Scenarios

**A.** September 16<sup>th</sup> - An elderly female schedules an appointment with you for screening. She reports that her husband was at a Service Organization meeting, heard you speak and is now convinced that she is depressed. She mentions coming in for the appointment to please him. The appointment lasts for 30 minutes. The client reports that she does not want to continue today and reschedules for September 23<sup>rd</sup>. Since the appointment was so brief, you are unable to complete a thorough assessment and decide to use the deferred diagnosis 799.9 for today's visit. (Brief Visit Type)

The agency you are working for uses the first contact date as the case open date. Please enter this case status information. Using your training ID, assign yourself as the Designated Provider for this client.

September 23<sup>rd</sup> - The client returns and completes the intake assessment. After reviewing the results of the interview with her, she agrees to enter treatment. She is still somewhat in denial but appears motivated to continue. You schedule another appointment to begin counseling next week. Use a diagnosis of 296.31, Major Depressive Disorder, Recurrent, Mild. (Intake Visit Type)

September 30<sup>th</sup> – the client returns for her appointment and agrees to a treatment plan that has been mutually developed, based on the assessment results. Enter a visit for individual therapy (Regular Visit Type) and a Treatment Plan.

Now that the treatment plan has been signed, enter a case status of admitted as of September 30<sup>th</sup>.

October 27<sup>th</sup> – During a regular counseling session, the client reports that she was abused physically as a child and has difficulties with relationships as a result of the abuse. She claims that she is unable to bond with other females, has few friends, and is only able to feel comfortable in social settings if she is drinking. When screened for alcohol and drug problems using the CAGE, the client replies affirmatively to two out of the four questions. Complete the visit documentation;

1. Add a Personal History of Child Abuse – Victim;
2. Add a screening for alcoholism POV;
3. Add a Health Factor of CAGE 2/4; and,
4. Record a referral to the local alcohol and drug abuse clinic.

November 3<sup>rd</sup> – The client has been making excellent progress in treatment – appears to be recognizing her symptoms and is beginning to respond to the antidepressant medication. She reports that her relationship with her husband has not improved significantly and he is refusing to enter into couple's therapy. She is feeling despondent over her husband's continued threats to leave her. During the counseling session, she admits that she has been thinking about killing herself. Further discussion reveals that she has a gun and has thought about going to her husband's camping cabin and shooting herself. She doesn't feel that she is important to anyone and believes that her family would be better off without her. After further discussion, she agrees to sign a No Harm contract and to call immediately if she feels like harming herself. She agrees to call her husband from your office to ask him to place the weapons in a safe location. Enter a Regular Visit Type using **Problem Code 39** and then complete a Suicide Surveillance Report.

November 4<sup>th</sup> – As agreed, the client calls to report her status. Her husband has given the guns to his brother temporarily and has talked to his wife about his feelings. She indicates that he is spending more time with her and that she is starting to feel hopeful. As agreed yesterday, you contacted her husband earlier in the day to verify that the guns have been safely stored. You mention to the client that her husband seems concerned about her wellbeing and has stated that he might be amenable to couple's counseling. Enter a telephone contact using the Brief Visit Type.

November 29<sup>th</sup> – Now that the client's husband has left her, you decide to conduct a formal assessment using one of the depression assessment tools as a means of reviewing her progress. Client expresses an understanding of her progress and the need to continue her medication and individual sessions. Document an encounter for this date, changing the diagnosis to 296.32, Major Depressive Disorder, Recurrent, Moderate.

December 15<sup>th</sup> – Due to the significant changes in the client's life, she agrees to complete a treatment plan review, adding additional information. Complete a Treatment Plan Review with the client present and yourself.

January 20<sup>th</sup> – The client reports that she would like to enter a Halfway House while she rebuilds her life. She states that she has recently lost her job because she is unable to concentrate and remains separated from her husband, so she is able to be away from the community for an extended period of time. Complete a Regular Visit Type and enter the Placement Disposition. Enter a Treatment Plan Review to record the plan as inactive. Enter a revised Case Status to indicate the client is discharged/transferred to another resource.

**B.** Using the scenario above, select any adult male patient. Change the diagnosis to Alcohol Dependency and complete data entry using the same dates of service. For the Intake visit, enter the following Staging Tool results:

**T**  
The client reported that he has at least three drinks each day but never uses drugs. He denies any arrests or hospitalizations related to his drinking. Client reports that he used to smoke but gave it up when his first child was born five years ago.

Alcohol/Substance	<b>2</b>	Physical	<b>3</b>	Emotional	<b>2</b>
Social	<b>3</b>	Cultural/Spiritual	<b>2</b>	Behavioral	<b>2</b>
Vocational/Educ	<b>3</b>				
Recommended Placement	<b>Primary Residential</b>	Actual Placement	<b>Intensive Outpatient</b>	Difference Reason	<b>Client's Choice</b>

*Values for Staging Tool*

**C.** The patient is a female with a diagnosis of Schizophrenia, Undifferentiated type. Patient reports that auditory hallucinations are present but not distressing, consistent with her usual baseline.

Appetite and sleep patterns are normal. Patient reports that she is doing well in her sheltered work program; continues to live at home with her parents and is getting along well with family members. Patient states she is binge drinking 1-2 times per week. Patient did not display any signs of akathisia, tremor or rigidity.

Brief Impression: Currently stable on meds

Plan: Continue current medication regimen; Olanzapine 10 mg. PO q hs. Continue participation in sheltered work program and SMI Case Management program. Refer to tribal A/SA program for further assessment of alcohol use.

Patient Education: Advised patient about weight-gain potential of Olanzapine and recommended that she decrease the amount of simple sugars in her diet.

Record as BH-M (Behavioral Health – Medication), 10 minutes, Fair

Health Factor: CAGE 2/4, Heavy, (Quantity not required)

**D.** A male child is referred to the Social Services Department by pediatric clinic staff. Dr. Elizabeth Johnson has evaluated the child and reports he has bruising consistent with an electrical cord being used for discipline. The alleged abuser is an uncle whose name is John B. He is the current legal guardian for the child and lives at 223 North Cliffside Road in Little Bigwater.

- The home address is the same as above.
- The natural parents have been deceased for 8 years.
- Officer Charley Smith has taken the complaint (#2334478) earlier today.
- There is a history of prior incidents reported in the medical record and by social services. The uncle apparently has a severe drinking problem.
- There is an aunt (Clarissa B., Box 23, Little Bigwater, telephone (520) 333-4333) who has taken the child in the past and is willing to do so again.
- The risk of re-injury appears high as the patient reports that the uncle threatened to “show you what a whipping is if you tell anyone about this”.

**Follow Up Visit – one week later**

A telephone call to Tribal Social Services reveals the uncle has been drinking heavily for several months. A criminal charge is in process of being adjudicated in court. The uncle has apparently admitted to inflicting the injuries “to keep his wildness under control – that boy don’t listen”. The boy has been placed for the foreseeable future with his aunt Clarissa B. and proceedings have been started to divest the uncle of guardianship.

The boy is also attending weekly counseling with the school counselor and appears to be adapting well into his new home.

Tribal Social Services is continuing the case until the guardianship issue is resolved and the placement with his aunt becomes permanent.

Risk of re-injury in current placement appears low.

Document the encounters using the SAN New and SAN Follow Up visits.

**E.** You are called to the local hospital emergency room to assist in determining if a teenager needs to go to an inpatient facility or can be treated successfully in the community. She had been transported to the ER following an overdose at school. While conducting your interview with the patient, she reveals that she was making a serious suicide attempt by trying to overdose on acetaminophen and denies any history of substance abuse. She then states that she has no prior history of substance use or abuse but does have two previous suicide attempts.. She shows you the scars on her wrists from one attempt and says that the other attempt involved jumping off a bridge into a lake.

Demographics: Use community where training is taking place as the community where the act occurred; use training ID as the provider ID; and select a date within the past 30 days as the date of occurrence.

Personal information: Not currently employed; single; and finished 10<sup>th</sup> grade in school.

**F.** Select any male in the 20-40 age range and record a No Show for a regularly scheduled appointment with you. The client did not call to cancel or reschedule. Since the client is on probation, you used 15 minutes of the allotted hour to prepare a report on frequent no shows for the probation officer.

**G.** Enter a regular visit with an IPV/DV Screening for a female client in the late teens – 40 age range.

### Objective #3: BH Options

Access the BH Options and record all required elements for group encounters, non-direct patient activities, and an encounter record in the Visit Entry format.

#### Purpose:

The purpose of this exercise is to introduce you to the BH Options which are view centric rather than patient centric. These include the group visit data entry fields, administrative records and the Visit Entry format.

#### Overview:

It is important that all users of the BH GUI, regardless of their discipline, be able to key in data for a group encounter visit, in the Visit Entry format and in an administrative record. Complete encounter data is critical for many reasons and helps to improve patient care, billing, and can be used to substantiate funding.

#### Skills You Will Acquire:

Upon completion of this objective you'll be able to:

- Enter all data elements for the group including the group SOAP/progress note
- Duplicate a previously defined group and enter all required information
- Generate a No Show note for a group member
- Enter data for administrative record keeping.
- Utilize the Visit Entry format to record a patient encounter

#### Log On

1. Log onto BH GUI; Select the BH tab
2. On the BH tab, click on the BH Options button
3. On the List View, use the calendars for the date range you wish to use and click [Display]. [Previous] and [Next] buttons may be used to move within the display.

#### Group - Adding Visit Information

1. Complete the demographics information at the top of the screen using the drop down menus. The required fields are the same as those for the other visit types and appear **bolded**.
2. Activity time in this location refers to the total time for the group, not an individual.

#### Group - Adding Group Data

1. Secondary provider – enter the name of any provider who assisted with the group.
2. Axis I/II: POV or DSM – required field. Enter the single diagnosis that fits all group members. In the above example, the user could enter 27, Alcohol Dependence; 30, Drug Abuse; etc.
3. SOAP (Standard Group Note) – enter only the group note here; individual notes will be entered later. This might contain information on the curriculum used for the group session or the topic that was discussed, etc.

**Reminder:** This section should never reference client-identifying information since it will appear on the printed note for each client.

4. CPT code – optional field.

### **Group - Adding Patients**

1. Click on the Patients tab.
2. Click on the [Add] button and use the display functions to select the patients who attended the group. Continue to click on the [Add] button until all patients are added.

### **Group - Adding Patient Data**

1. Click on the Patient Data tab.
2. Select the first patient's name by double clicking on the name to pull up the patient's data.
3. If adding an additional diagnosis, click [Add] and select the diagnosis to be added in the secondary position on Axis I/II.
4. Click in the SOAP box to add an individual progress note explaining the patient's participation in the group and progress made towards the objective.

**Reminder:** The Time in Group field is used to record the actual time a patient spends in the Group Session. Often time a person arrives late and leaves early and is unable to fully participate. E.g., the group meets for 90 minutes but this patient only attends for 45 minutes. Record 45 in the Time in Group field.

5. Click [OK] once changes have been completed and select the next patient to edit.
6. Continue with the same process until all relevant individual information has been added for each of the clients.
7. Click [Save] and choose the type of encounter form to be printed for each client.
8. Click [Display] to review the information and then click [Print] to print a form for each client.

### **Group – Duplicating a Previously Defined**

1. On the Group List View, highlight the group to be duplicated and press [Duplicate].
2. Review the group information for accuracy and change the group note as needed.
3. On the Patient tab, add any new group members. **Do not remove No shows.**
4. On the Patient Data tab, select the first patient's name by double clicking on the name to pull up the patient's data.
5. If adding an additional diagnosis, click [Add] and select the diagnosis to be added in the secondary position on Axis I/II.
6. Click in the SOAP box to add an individual progress note explaining the patient's participation in the group and progress made towards the objective.
7. Click [OK] once changes have been completed and select the next patient to edit.
8. No Shows – if a patient was a no show for this particular session, access his data on the Patient Data tab and enter [0] for the time in group. This will generate a no show encounter record with a note indicating that the patient failed to attend. **Although information can't be added to the SOAP /group note section, the user may add additional information in the Comment field.**

### **Group - Viewing**

This function will allow the user to view the group documentation; however, no changes can be made.

1. On the Group Entry List View, highlight the record to be viewed.
2. Click on the [View] key.
3. Click on the [Close] button to return to the list view.

## **Group – Deleting**

Deleting the group entry on the list view will not remove the individual encounter records for the clients. If you entered the group in error, remove the group entry then go to each client's individual list view and remove the encounter records one at a time.

1. On the Group Entry List View, highlight the record to be deleted.
2. Click on the [Delete] key.
3. Confirm the deletion.

## **Group - Printing or Viewing the Encounter Records**

1. On the Group Entry List View, highlight the Group you want to view or print.
2. Click on the [Print] button.
3. Select the Encounter Record print function – full, suppressed, etc. and then click [Display].
4. Review the encounter records onscreen and then click on the [Print] button to generate a hard copy, if desired.

## **Admin Records - Add**

1. Click the [Add] button to enter a new record.
2. If the program type is not defaulted to your particular clinic, use the drop down menu & select a program – mental health, social services, chemical dependency, or other.
3. Use drop down menus to enter other data.
4. Enter activity time as minutes. For example, six hours = 360 minutes.
5. Use the Provider Narrative box to enter a description of the activity such as the course name or continuing education.
6. Add any comments in the free-text field
7. Save the entry.

## **Admin Records - Editing**

1. At the Admin Record List View, highlight the record to be modified and click [Edit].
2. Make the necessary changes and then click [Save].

## **Admin Records - Deleting**

1. At the Admin Record List View, highlight the record to be deleted.
2. Click [Delete]

## **Admin Records - Printing**

1. Return to the Admin Record List View and highlight the event to be printed.
2. Click [Print]
3. Select the Display function – Full Encounter form, Suppressed, etc. and click [Display].
4. Review the record and then click [Print] to generate a hard copy.

## **Visit Entry**

The visit entry option allows you to add, edit, delete or print a Behavioral Health visit. You will only see this option if you have been assigned the BPCBHV security key.

1. On the main menu, click [BH Options].
2. On the Behavioral Health Options screen, click [Administrative Entry].
3. On the List View, use the calendars for the date range you wish to use and click [Display]. [Previous] and [Next] buttons may be used to move within the display.
4. Once the List View is displayed, follow the same data entry procedures as described in Objective #2, Patient Related Data Entry.

## Practice Scenarios

**A.** You are the facilitator for a medication education group for clients diagnosed with Major Depressive Disorder, Single episode, in partial remission. You follow the IHS patient education protocol for Behavioral Health – Medication during this one-hour group session. Today, only three of the group members attended. Two were attentive but did not actively participate in the discussion. The third group member was quite engaged and talked frequently.

Enter the group data for this scenario. Select a date that is at least one week ago. Add both the group note and individual notes for each client. Then duplicate the group and record information for today's session. Zero out the time for one group member in order to generate the No Show note.

**B.** You are the facilitator of a Children of Alcoholics therapy group that meets at the clinic every Wednesday night for two hours. Tonight you have four clients who have attended to discuss the first two Chapters of Claudia Black's book. The group focuses on her statement that there is an Elephant in the Living Room and its implications in their own lives.

POV/Diagnosis for the group is 62, Other Family Life Problems and the Activity Code is 91, Group Treatment (please change the narrative to "Clinic Visit"). During the group tonight, one of the clients acknowledges that she has a problem with alcohol and group members spend some time discussing this and the possibility that other group members may have some dependency issues also. Add a chemical dependency POV or DSM diagnosis to one of the group members. One of the other group members became upset when the group began discussing the possibility that they may also have dependency issues. She left the group at the end of the first hour rather than staying for the whole group session.

**C.** You are attending RPMS BH GUI training for two days. Each day's training last six hours or 360 minutes. Record your time in this training as an administrative entry. Change the narrative to indicate that this was BH GUI training. Comments are optional.

**D.** You are participating in a two-hour community health fair – operating a booth to provide information on mental health services. Record this as an administrative entry.

- E.** Using the BH Options, Visit Entry format enter a visit for the following scenarios:
1. The client is a male in his 20s who has missed his last three appointments and did not come in today. You use 30 minutes to do a chart review.
  2. The client is a male in his 40s who has been discharged from inpatient mental health treatment. You are seeing him today for medication monitoring.
  3. The client is a female in her 20s who has asked for assistance with food for her children and transportation to medical appointments for her youngest child.

## Objective #4: Reports

Use the Telnet function to access the Reports menu in BHS v3.0, identify specific reports, and run a sample report.

### Purpose:

The purpose of this exercise is to introduce you to the various types of reports that can be generated through BHS v3.0.

### Overview:

It is important that all users of the BH GUI, regardless of their discipline, be able to generate a report showing patient contacts, a clinician's active client list, or Treatment Plans needing revised. Generating reports enables the provider to monitor encounter data for accuracy, manage resources efficiently and provide encounter data to governing bodies, funding sources, etc.

### Skills You Will Acquire:

Upon completion of this objective you'll be able to:

- Identifying reports that can be generated in BHS v3.0.
- Selecting report parameters including time frames, clinicians, types of visits, etc.
- Generate reports to display an individual clinician's active client list, treatment plans needing revised, IPV/DV screenings completed, and aggregated suicide data.

### Log On

1. Access BHS v3.0.
2. Enter your access and verify codes and click [Enter].
3. Type in the Behavioral Health program title from the menu and click [Enter].
4. Type in "RPTS" and click [Enter] to access the Reports menu.

**Reminder:** BHS v3.0 is not mouse friendly; use the Tab and Enter keys to navigate.

### Generating an Active Client List

1. Type [PAT] to select Patient Listings Reports and click [Enter]
2. Type [ACL] for an Active Client List and click [Enter]
3. Type a Beginning Date and click [Enter]
4. Type an Ending Date and click [Enter]
5. If you are interested in one particular provider's caseload, type [Y] and click [Enter] when asked "Limit the list to those patients who have seen a particular provider?" If you want to see the information for all providers at your clinic (or in this class), type [N] and click [Enter]
6. If you answered [Yes], type in the provider's name (last name,first) and click [Enter]
7. Click [Print] to generate a hard copy of the report, or click "Browse" to view the report onscreen
8. Follow the onscreen instructions to return to the Report Menu after completing this activity.

### **Generating a Treatment Plans Needing Resolved Report**

1. Return to the Reports menu, type "PAT" and click [Enter]
2. Type "TPR" and click [Enter]
3. Type a Beginning Date and click [Enter]
4. Type an Ending Date and click [Enter]
5. If you are interested in one particular provider's caseload, type in a [Y] and click [Enter] when asked "Limit the list to those patients who have seen a particular provider?" If you want to see the information for all providers at your clinic (or in this class), type [N] and click [Enter]
6. If you answered [Yes], type in the provider's name (last name, first) and click [Enter]
7. Click [Print] to generate a hard copy of the report, or click [Browse] to view the report onscreen
8. Follow the onscreen instructions to return to the Report Menu after completing this activity.

### **Generating an IPV/DV Screenings Report (controlled by a security key)**

1. Return to the Reports menu, type "PAT" and click [Enter]
2. Type [DVR]– IPV/DV and click [Enter]
3. Type [DVP] – Tally/List Patients with IPV/DV Screenings and click [Enter]
4. Type a Beginning Date and an End Date
5. At the next prompt, select all the items you wish to tally.
6. Answer all the remaining categories to select the data you wish to view.
7. Select [Browse] or [Print].

### **Generating an Aggregate Suicide Report**

8. Return to the Reports menu, type "PROB" and click [Enter]
9. Type "SSR"– aggregate Suicide data – and click [Enter]
10. Type a Beginning Date and an End Date
11. Type an "A" for all communities or "O" for one community
12. If one community is selected, enter the name of that community and click [Enter]
13. Type a "P" to print the report or a "B" to review it on your computer screen.

### ***Practice Scenarios***

**A.** Generate a caseload report for all providers who saw patients within the past 30 days. Browse it on your computer screen.

**B.** Generate a Report of Treatment Plans Needing Review using the beginning date of 30 days ago (T-30) and the ending date of 60 days from today (T+ 60). Select all providers for the report. Browse the report on your computer.

**C.** Generate an IPV/DV Screening report for the past 90 days. Include information from other clinics and the name of the mental health, social services, or substance abuse provider. Browse the report on your computer.

**D.** Generate an Aggregate Suicide Report for all communities using a beginning date of 6 months ago and an end date of the last day of the previous month. Browse the report on your computer.

## Objective #5: Exporting

Routinely export behavioral health data to headquarters using the Export utility menu.

### Purpose:

The purpose of this exercise is to discuss and demonstrate the Exporting process.

### Overview:

It is important that all users of the BH GUI, regardless of their discipline, demonstrate an understanding of the data exporting process.

## Manager Utilities Menu

The Manager Utilities menu provides options for Site Managers and program supervisors to customize the Behavioral Health System to suit their site's needs. Options are also available for administrative functions, including the export of data to the Area, re-setting local flag fields, and verifying users who have edited particular patient records.

**Note:** *Not all users of the Behavioral Health System will be given access to this menu.*

## Export Utility Menu

Use this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes. (Most users will not have access to this menu option).

These options should be familiar to site managers. The recommended sequence for their use follows those from PCC- CHK, clean, GEN, DISP, ERRS, transmit. RGEN, RSET and OUTP should be reserved for expert use as required.

```
__GEN__Generate_Transactions_for_HQ_  
__DISP__Display_a_Log_Entry_  
__PRNT__Print_Export_Log_  
__RGEN__Re-generate_Transactions_  
__RSET__Re-set_Data_Export_Log_  
__CHK__Check_Records_Before_Export_  
__ERRS__Print_Error_List_for_Export_  
__OUTP__Create_OUTPUT_File_
```

## Generate Transactions for HQ

This routine will generate BHS transactions to HQ. The transactions are for records posted between a specified range of dates. If you type ^ at any prompt, you will be asked to confirm your entries before generating transactions.

To generate BHS transactions to Headquarters, type GEN at the "Select Export Utility Menu Option:" prompt.

Type information as requested at the prompts that follow to record each entry.

### **Print Export Log**

Use this option to print an export log.

- Type PRNT at the “Select Export Utility Menu Option:” prompt.
- Type information as requested at the prompts that follow and press the Return key to record each entry.

### **Check Records before Export**

Use this option to review all records that have been posted to the BHS database since the last export was performed.

- Type CHK at the “Select Export Utility Menu Option:” prompt.  
Note: This option will review all records that were posted from the day after the last date of that run up until two days ago.
- Type the information as requested at the prompts that follow and press the Return key to record each entry.

### **Print Error List for Export**

Use this report to review all records that have been posted to the database and are still in error AFTER the latest Export/Generation.

- Type ERRS at the “Select Export Utility Menu Option:” prompt.  
Note: The Check Records before Export option should have been used to determine all errors before running the generation. You may now correct these errors before the next export/generation.
- Type information as requested at the prompts that follow and press the Return key to record each entry.

## **Contact Information**

If you have any questions or comments regarding this distribution, please contact the OIT Service Center by:

**Phone:** (505) 248-4371 or  
(888) 830-7280

**Fax:** (505) 248-4363

**Web:** <http://www.rpms.ihs.gov/TechSupp.asp>

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